FREE WEBINAR
Home Health

A New Approach for **Face-to-Face**

Updated Info, Updated Insights

with
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Why the scrutiny?

During FY 2013: 17.3% of payments made were considered “improper” = $3 billion

During FY 2014: 51.4% of the payments were considered “improper” = $9 billion

Improper Payment:

- Funds go to the wrong recipient
- Correct recipient receives the incorrect amount of funds,
- Documentation is not available to support a payment
- Provider uses funds in an improper manner

HAVE YOU HEARD?

Prior Authorization/Pre-Claim Review (PCR)

The original CMS timeline for the Prior Authorization demonstration for homecare agencies is as below:

Illinois – August 1, 2016 *(began Aug 3, 2016)* Currently on temporary hold for claims effective April 1, 2017.

Florida – October 1, 2016 *(did not begin)* ON HOLD

Texas – December 1, 2016 *(did not begin)* ON HOLD

Michigan and Massachusetts – January 1, 2016 *(did not begin)* ON HOLD

Pre-Claim Review – WHY?

Fraud Prevention activity

- CMS indicates it will *"test improved methods for identifying, investigating, and prosecuting 'Medicare fraud' while maintaining or improving the quality of care provided to Medicare beneficiaries"*

PCR Documentation Requirements

All documents and information supporting medical necessity and level of care prescribed.

- OASIS
- Plan of Care
- Face-to-Face
- Hospital Information
- Therapy/Social Worker Assessments
- Medication sheet
- Pertinent labs/other test results

Risk for Pre-Payment Review

If a FINAL claim is submitted for payment WITHOUT a PCR:

- The claim will go into a complete pre-payment review.
- If allowed, the final claim will be paid with a 25% reduction in the FULL CLAIM amount!

Face-to-Face

How did we get here?

- Face-to-Face is a statutory anti-fraud provision

Details Behind the Face-to-Face Rule

CMS "Medicare Benefit Policy Manual" CMS Pub. 100-02 Chapter 7; Home Health

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c07.pdf

Qualifying Criteria for Home Health Services

1. Physician orders, plan of care and certification
   - Face-to-Face encounter
2. Homebound
3. Intermittent/part-time skilled nursing
4. Medically reasonable and necessary services are provided

Change Request 9119

1. CMS eliminated the narrative requirements

2. If the agency claim is denied, the certifying/recertifying physician claim is **non-covered** since there is no corresponding claim

3. Clarification that the Face-to-Face encounter is required for initial certification (Starts of Care) rather than re-certifications.
   - Note: This does NOT remove the need to send the original Face-to-Face with recertification requests for medical review

Change Request 9119

Effective January 1, 2015, documentation in the certifying physician's medical record and/or acute/post-acute care facility's medical record:

- Will be used as a basis for patient's home health eligibility;
- Must contain information to justify the referral for home health services, including:
  - Need for skilled services

    and
  - Homebound Status
- This information "must be provided to home health agency when requested"

DOCUMENTATION MUST INDICATE WHY HOMECARE AND WHY NOW!

Change Request 9119

- Medicare Benefit Policy Manual Ch. 7 section 30.5.1.2 indicates "the certifying physician and/or acute/post-acute facility medical record (if the patient admitted to agency directly from facility) for the patient MUST CONTAIN THE ACTUAL CLINICAL NOTE FOR THE FTF ENCOUNTER VISIT THAT DEMONSTRATES THAT THE ENCOUNTER…
  - Occurred within required timeframe
  - Was related to primary reason patient requires home health services

    and
  - Was performed by an allowed provider type.

Multiple Changes

The F2F rule has been challenged in federal court, but to no avail.

Multiple Revisions by CMS

- **2011:** Allowed the facility physician to communicate findings to community physician. The community physician could then "adopt" this documentation and rely on it to prepare the Face-to-Face documentation.
- **2012:** Clarified that the facility physician could initiate the plan of care and complete the certification, including the Face-to-Face.
- **2013:** Allowed the non-physician practitioner working with the facility physician to perform the Face-to-Face.
  - *ALSO ALLOWED:* The agency to date and title the document.

Multiple Changes

Despite changes and clarifications,

the Face-to-Face problem has gotten **WORSE!!!!**

CERT Reviews

2013 analysis of CERT reviews indicated **17.3% improper payment rates.**

- 2nd highest percentage and largest in terms of projected improperly paid claims.
- The areas leading to this rate are areas on which agencies must focus their attention and prepare for audits.

CERT Reviews

Reasons for errors:

- Insufficient Documentation: 81.4%
- Lack of Medical Necessity: 15.8%
- Incorrect Coding: 1.1%

IN 2012, THE ERROR RATE WAS ONLY 6.1%

INSUFFICIENT DOCUMENTATION WAS 45% IN 2012 AND **INCREASED TO 81.4% IN 2013.**

Face-to-Face and CERTs

- Auditors are denying narratives by physicians, resulting in high take backs.
- Physician narrative was the biggest reason for insufficient documentation.
- NOW: dates and illegibility are causing massive denials.

ERRORS COST THE INDUSTRY

$3 BILLION

How Do You Spell *Relief???*

Eliminated narrative on a Face-to-Face form.

CMS indicated the medical record would be sufficient.

The rule eliminated the separate and distinct requirement and the need for a title on the form.

The Physician must document:

- A F2F encounter occurred
- The date of the encounter
- That the encounter was related to the primary reason the patient requires home health
- That the encounter occurred no more than 90 days prior and 30 days after the HH SOC visit
- That the encounter was performed by physician or allowed non-physician practitioner

How Do You Spell *Relief???*

PROBLEM:

- The Agency is 100% dependent on the information in the physician's progress note.
- Physicians ONLY document their encounters for billing purposes. Typically, this does not provide the specific information we need for Face-to-Face.
- Physicians do not understand home health eligibility, and therefore, do not document accordingly
- Auditors are still looking for narratives, **not just that the encounter occurred.**
- Agencies have MUCH influence supporting the physician documentation.

MAC Audits

- Elimination of the narrative (as a result of misunderstanding) and the form made things much, much worse!
- Results so far (audit-wise) are worse than ever before.
  - NGS said on a provider outreach call that it had denied 300 of 309 claims so far during the probe (97.1%).
  - CGS has reviewed 595 claims and partially or fully denied 508 of them — an 85% rate.
  - Palmetto=>85%
  - CERT error rate is up to 81.4%
  - Face-to-Face audit (cert) is at 90%

Face-to-Face REQUIREMENTS

- Is the Face-to-Face encounter documentation for the correct beneficiary?
- Does the Face-to-Face encounter occur within 90 days prior to SOC or within 30 days following the SOC?
- Is the Face-to-Face encounter performed by a physician or an allowed non-physician practitioner (NPP) **and** does the Face-to-Face encounter document include a date when the physician or allowed NPP performed the encounter?
- Is the date the physician or allowed non-physician practitioner signed the Face-to-Face encounter **legible**?
- Does the documentation describe how the patient's clinical findings (as seen during that encounter) support the patient's need for skilled services and homebound status?

Face-to-Face REQUIREMENTS *(cont.)*

- Is there any documentation that was created/generated by the home health agency, sent to the physician and now incorporated in the physician held medical record, and signed off by the certifying physician and/or acute/post-acute care facility?

OTHER REGARDING:

Face-to-Face MAC comments

NGS: Reminds providers that a Face-to-Face encounter form is NOT adequate documentation to support Face-to-Face has occurred.

Checklist recommendations:

- Discharge summary from the acute or post-acute care facility written at the time of patient discharge prompting referral to the agency;
- Progress note from the physician's office written at the time of the patient one on one visit with the physician in the office prompting referral to the agency
- Mandatory narrative regarding skilled oversight of unskilled care (if occurred)
- **A non-physician practitioner may complete and sign the FTF encounter **without a counter signature**

OTHER RE:

Face-to-Face MAC comments

CGS (example):

- If the hospitalist certifies the patient for home health but will not follow the patient after discharge, he/she must identify the community physician who will follow the patient.
- The certifying physician does not need to cosign the Face-to-Face document. The certifying physician just needs to have the date the Face-to-Face encounter was completed.
- CGS does not require the primary diagnosis to match the F2F encounter focus, but the main reason the agency is seeing the patient. For example, if the face-to-face was dealing with therapy, but diabetes was the primary diagnosis, the claim would be re-coded accordingly and if therapy services were not included on the plan of care, the claim would be subject to denial.

Other Audit Issues Regarding:

Face-to-Face & Support Documentation

SMRC (Supplemental Medical Review Contactor)

Reviewed 52,223 claims with service dates July1, 2011-April 30, 2013

Only 81.7% of ADR's were sent to SMRC

1,396 claims were deemed invalid to review

Of the 50,827 remaining claims:

- 41,513 were reviewed
- 9,314 were denied for no response to the ADR
- 15,707 denied in medical review
- TOTAL: 25,021 total claims denied-error rate of 49%!!!!

62% of denials were due to medical record documentation not supporting services provided

Agency Mistakes

- Continuing the “old” way of documenting Face-to-Face encounters
- Not pursuing physician generated supporting information (relying on agency encounter forms)
- Not checking legibility of documentation supplied
- Not sending required information upon request
- Not checking encounter status/documents at time of service
- Relying on physician addendum letters/attestation letters to support services
- Poorly formatted Face-to-Face encounter forms

Agency Mistakes *(cont)*

- Not responding to the Additional Development Request (ADR) - **100% sure denial**
- SMRC review project on Face-to-Face had 22% denied due to no response to ADR
- Relying on agency generated Face-to-Face forms

Agency Mistakes *(cont)*

- Encounter untimely - 90 days prior/30 days after SOC
- Date of encounter not documented
- Certification of encounter not present
- Reason for encounter is not principal reason for home health care
- Physician signature not dated
- Certifying physician was not the same physician who conducted the Face-to-Face encounter and no documentation or communication between them
- Home health agency information does not corroborate Face-to-Face encounter content and findings
- Date of documents does not match encounter date

FTF Documentation *Don'ts*

Insufficient Documentation:

- Diagnosis/clinical findings on FTF **not related** to homecare ordered*
- Altered documentation without acceptable notations for changes*
- No date of FTF encounter*

Documentation *Do's*

Be sure ALL services are reasonable and medically necessary related to the patient's condition.

Be sure documentation clearly answers the question **"Why Homecare and Why Now?"**

Assure the following in documentation in general:

- Objective clinical evidence of patient's individual need for care
- Progress or lack of progress
- Medical condition
- Functional losses
- Treatment goals
- Discharge planning

Examples of "Good Documentation"

"Lungs sound coarse throughout. Patient finished antibiotic therapy today for pneumonia, and seeing pulmonologist tomorrow for follow up due to COPD and emphysema."

____

"Stasis wound on LLE continues to show 50% granulation and moderate serous drainage. Instructed patient on need to elevate legs and exercises related to peripheral vascular disease."

Other Reasons for Denial

- Encounter not sent with medical review
- Supporting physician generated documents are ***not present***
- Supporting physician generated documents are ***incomplete***

Palmetto Denial Explanation

“Upon further review, the physician’s history and physical did not support Face-to-Face requirements and/or could not be used as the basis for certification of patient eligibility.

There was not additional documentation in the certifying physicians medical record, such as inpatient/hospital medical records.

Or clinical documentation submitted or review to support Face-to-Face requirements and/or be used as the basis for certification of patient eligibility.”

Then, they cite Medicare Guidelines.

Preventative Measures

- ❑ Carefully review ADR's
- ❑ Review certification statement on the Plan of Care, includes Face-to-Face encounter
- ❑ Identify delayed encounters if they are done after admission. **Flag for billing!**
- ❑ Use chart review checklist for documents to include
- ❑ Review ALL encounter documents received — give feedback or return to physician if incomplete
- ❑ Provide MLN SE 1436 as education
- ❑ Review MLN SE 1436 with management/supervision/quality assurance staff
- ❑ Review each Medicare Administrative Contractors educational materials
  - *SCIO's
  - *Advanced Med

Preventative Measures

- ❑ Check signature/dates of documents
- ❑ Check that "date of encounter" is clearly documented
- ❑ Check documents are labeled and include Face-to-Face (the agency is permitted to add)
- ❑ May include physician addendum-follows guidelines of CMS Pub. 100-08, Chapter 3, Section 3.3.2.4 (Program Integrity Manual)

Face-to-Face: Pre-2015

NOT required on a Face-to-Face encounter:

- Separate sections for clinical and homebound findings
- Disciplines to be provided
- Diagnoses (listing)
- Homebound certification statement
- Orders for homecare services (what services should be performed)

Two Homebound Criteria

Criterion 1

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, cane, wheelchair, and walker; the use of special transportation; or the assistance of another person in order to leave their place of residence.

OR

- Have a condition such that leaving his or her home is medically contraindicated.

Two Homebound Criteria

Criterion 2

- There must exist a normal inability to leave home.

AND

- Leaving home must require a considerable and taxing effort.

Homebound Criteria *(cont.)*

Documentation in the clinical record **must** support the homebound status throughout **all** disciplines.

Be careful not to use non-specific terms like "taxing effort" or "unable to leave home."

Use **objective** and **measureable** language.

EXAMPLE:

- *"After ambulating 20 feet, patient has significant dyspnea; SaO2 drops from 92% to 86% in room air and pain increased from a level 2 to level 6."*

2015 Changes to Face-to-Face

1. Agency must make available UPON REQUEST the supporting documents for the Face-to-Face encounter:
   - Physician note
   - Hospital record, etc.

2. Agency generated clinical findings no longer deemed sufficient to support compliance

Per CMS: *"Information from the HHA (agency), such as the initial and/or comprehensive assessment of the patient required per 42 CFR 484.55, can be incorporated into the certifying physician's medical record for the patient and used to support the patient's homebound status and need for skilled care.*

However, this information must be corroborated by other medical record entries in in the certifying physician's and/or acute/post acute care facility's medical record for the patient.

Certification requirement includes Face-to-Face encounter."

Face-to-Face Appeals: 2015

Must be in compliance with CMS Pub. 100-02, Chapter 7, Section 30.5.1.1 and 30.5.1.2

- ❑ Date of encounter
- ❑ Signature
- ❑ Timing of Signature

If all of this is ***not*** present, you cannot appeal.

Face-to-Face Appeals: 2015

- Review **everything** included in the ADR request.
- If missing items on original submissions, secure and send with appeal.
- Review content of physician's generated documents. ***Explain content.***
- *If legibility issues:* get a legible transcription and attestation from physician.
- *If incomplete:* get an addendum and attestation from physician.

Face-to-Face Attestation

- Original Face-to-Face encounter must be present prior to submission of final bill.
- If adding items after billing, it is best to do with Physician Attestation Letter.
- Be sure letter is ***dated*** when completed, and identifies the date of encounter to which attestation applies.
- Clarification findings are present with statement by physician that information is accurate, made under penalty of civil or criminal liability (the attestation).

Refer to: CMS Pub., 100-08, Chapter 3, section 3.3.2.4

Recertification CR 9119

New Requirement:

The physician must include an estimate of how much longer skilled services will be required.

- This estimate may be longer than the benefit period
- The ordered frequency/dates (on plan of care) **CANNOT** be used as the physician's estimate
- Statement indicated the clinical need for services to continue

Low Hanging Fruit for the Federal Government

- Many providers have never read about or heard about this rule established in the Final Rule for 2015.
- Agencies that do not know about or understand this requirement risk losing hundreds of thousands of dollars.

Looks Like a Cake Walk

The cost and effort associated with this could make Face-to-Face look like a "cake walk" when medical reviews/audits and, subsequent, denials based on recertification narratives begin.

Section 424.22

(2) *Content and basis of recertification.* The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy.

Tips on Compliance with the Rule

Establish need.

When re-certifications occur, the case manager should communicate with the patient and all team members to determine the need for the recertification and estimate a timeframe for the patient goals and interventions to be accomplished.

This should be an interactive coordination of the reason the goals were not met during the previous episode and just what changes in the plan will be made to better address the goals and interventions.

Tips on Compliance with the Rule

Read Medicare policy.

Be sure the need for recertification is related to items that are covered in the Medicare policy manual.

For instance:

- *Setting up medication planners* is not a covered service
- *Observation and assessment* is not a covered service beyond a 3 week period ***unless*** there is very good documentation as to why that patient qualifies, etc.

Tips on Compliance with the Rule

Unique statement.

A written statement that reflects the unique needs of the patient should be clearly documented on the plan of care. We recommend the agency place this statement at the END of Box 21 *(Interventions)* on the plan of care.

Tips on Compliance with the Rule

Estimate date.

As in the" finite and predictable end point" in the daily skilled nursing rule, this date is an ***estimate*** and should not be considered documentation of a final discharge date.

We recommend this date be generous. It is better to predict a date that is likely to be more extended than actually predicted.

This allows for patient changes.

- (When you create a short (time) estimate on the number of months or episodes, you will need to make changes in that date, creating questions as to whether or not the team actually understands how to determine plans).

It's better to overestimate than underestimate a potential discharge date. CGS is recommending that the agency leave a **blank** for the physician to document the actual estimation of a date.

However, there is ***nothing*** in the rule that specifies this requirement. **Proceed with caution.**

Tips on Compliance with the Rule

Physician signature and date.

Be certain there is a place for the physician to sign and date directly underneath the Recertification Statement. Remind the physician (by highlighting or placing a note near the area for signature) that this additional signature is a requirement.

Simply signing the plan of care indicating need for certification and that the patient is homebound is not enough.

Tips on Compliance with the Rule

Recertification Statement

Patient to be recertified for continued need for wound care. Wound now measures 2.5cms in width and is 1 cm deep. There are no willing and available caregivers to teach. Estimate end date for re-certifications to be on or near ________(date).

Physician Signature_______________ Date ______

SUMMARY:

Complying with the F2F Rule

1. Encourage physician compliance

2. Involve your marketing/sales/liaison staff for interaction with physicians

3. Learn how to create a **physician's packet** to supplement physician progress note
   - OASIS items related to diagnosis
   - Current Medications
   - Medical Update

4. Assure documentation is ***the best it can be.***
   - Create a **Continuous Documentation Improvement** process
   - Make critiquing documentation *a living part* of your daily routine
   - **Hold staff accountable**
     - Review documentation policies
     - Review contracts with contracted staff, i.e. therapists, social workers, etc.

SUMMARY:

A Face-to-Face Checklist

A Palmetto Document

General Requirements

1. Encounter must be performed within the required timeframe.
2. Must be signed and dated prior to the submission of the claim for billing.
3. Must contain the date of the encounter.
4. If the encounter was performed by a non-physician, **be sure** the primary physician's documentation in the clinical record corroborates the documentation.
5. Information submitted by the HHA must corroborate with other medical record entries and is aligned with the time period when services were rendered.
6. The information submitted by the agency must be signed by the physician.

SUMMARY:

A Face-to-Face Checklist

A Palmetto Document

Documentation to support the need for home health services.

1. Documentation must describe the patient’s condition and symptoms — not simply a list of diagnoses.
2. Identify the reason for the homecare services to be ordered:
   - New Problem?
   - Exacerbation of a previous/existing problem
3. If this is a post-op patient
   - Identify date of surgery
   - Identify any complications
4. If pain is a symptom
   - Is this a new onset of pain?
   - Identify pain severity

SUMMARY:

A Face-to-Face Checklist

A Palmetto Document

Documentation to support the need for skilled physical therapy services.

1. Documentation must identify the need for PT services
   - ❑ Restore function?
   - ❑ Design or establish a maintenance program
   - ❑ Perform maintenance therapy

2. There must be clear documentation with ***evidence*** of PT need — to include, but not limited to:
   - ❑ Assessment of functional deficits and home safety evaluation
   - ❑ Therapeutic Exercises
   - ❑ Restoration of joint function for post-joint replacement patients
   - ❑ Gait Training
   - ❑ ADL Training
   - ❑ Other ______

SUMMARY:

A Face-to-Face Checklist

A Palmetto Document

Documentation to support the need for skilled speech therapy services.

1. Documentation must identify the need for ST services
   - ❑ Therapeutic exercise to improve swallowing and/or language function
   - ❑ Therapeutic exercise to improve cognitive function
   - ❑ Perform maintenance therapy

SUMMARY:

A Face-to-Face Checklist

A Palmetto Document

Documentation to support the need for skilled nursing services.

1. Documentation must identify the need for ST services.
   - ❑ Identify teaching/training to be done. ***Why is it needed?***
   - ❑ Identify observation & assessment. ***Why is it needed?***
   - ❑ Identify complex care management. Management and Eval: unskilled need/unskilled caregiver.
   - ❑ Identify any medications you will administer.
   - ❑ Identify psychiatric need/evaluation/therapy that will take place.
   - ❑ Identify rehab nursing.
   - ❑ Identify direct nursing care to be performed.

Resources

IOM Medicare Benefit Policy Manual Pub. 100-02, Chapter 7, Section 30.5.1.1

IOM Medicare Benefit Policy Manual Pub. 100-02, Chapter 7, Section 30.5.1.2

42 CFR 424.22

Med Learn Matters MLN MM9119

Med Learn Matters MLN SE1436

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https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html

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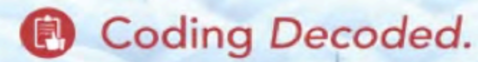

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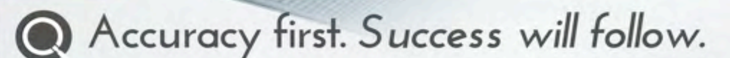

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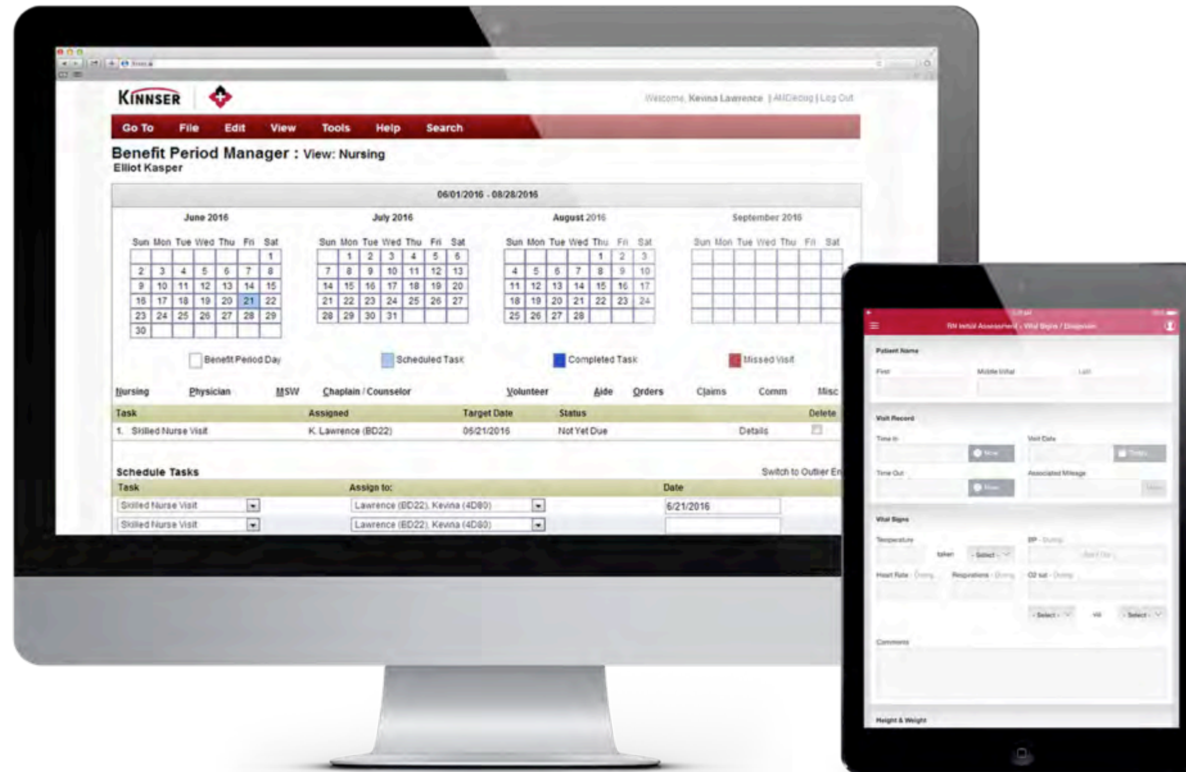

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